Centers for Medicare & Medicaid Services
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Contents

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Welcome

Good afternoon, my name is Melissa MacLean with the CMS Consumer Support Group. I want to welcome you to our weekly assister webinar. Before we start the presentation today, I will go over a few technical issues with you. All lines have been muted to prevent background noise. If you're listening through computer speakers or have any audio issues you can refresh the webinar. It is the third icon in the row near the volume bar. If you continue to have problems you are welcome to contact us via telephone. Instructions are included in the alternate audio tab. You can ask your questions by typing them into the "ask a question" tab. I will now turn over the webinar to Deborah Bryant.

Good afternoon! Thank you for joining us today and welcome to our weekly assister call. My name is Deborah Bryant, and I'm the Director of the Transparency and Disclosures Division of the Consumer Support Group for the Marketplace.

As a reminder, this call is intended as a technical assistance call for assisters. It is not intended for press purposes and is not on the record. If you are a member of the press, please email our press office at press@cms.hhs.gov. Please note that the information presented in this webinar is informal technical assistance for assisters and is not intended as official CMS guidance.

On today's webinar, we'll provide several Marketplace updates, including a brief overview of HHS's recently proposed rule on Nondiscrimination in Health Programs and Activities and how it affects assisters. We also have a presentation on periodic data matching for consumers enrolled in both a qualified health plan with subsidies, as well as in Medicaid or the Children's Health Insurance Program. And our last presentation for today will provide an overview and tips on helping these consumers terminate their QHP coverage with subsidies if they are both enrolled in Medicaid/CHIP and a QHP with APTC/CSRs.

If you have questions throughout today's webinar, please submit them through the webinar chat feature. If we have time at the end of the webinar, we'll answer some of the questions you've submitted. And with that I'll turn it over to Michelle Koltov who will moderate today's session. Michelle?

Marketplace Updates

Thanks Deborah. Before we begin our presentations today, we have some Marketplace updates. First, we're joined by Sarah Albrecht, who is a Civil Rights Analyst with the HHS Office for Civil Rights, to talk about HHS's recently proposed rule on nondiscrimination in health programs and activities, which implements section 1557 of the Affordable Care Act. She'll talk about how this proposed rule would apply to Marketplaces and qualified health plans, and what it will mean for assisters. Sarah?

Nondiscrimination in Health Programs and Activities

Thank you, Michelle. This is Sarah Albrecht with the US Department of Health and Human Services Office for Civil Rights, or OCR for short. I appreciate the opportunity to talk to you today about an important proposed regulation that the department recently issued to implement section 1557 of the Affordable Care Act. Section 1557 is an opportunity to advance health equity and reduce health disparities in health services and coverage.

Section 1557 is the civil rights provision of the Affordable Care Act. It says that individuals cannot be subject to discrimination based on their race, color, national origin, sex, age, or disability. The proposed rules strengthens protections against discrimination and advances this Administration's commitment to ensuring that every American has access to the health care that they deserve. The proposed rule combines and harmonizes existing well-established federal civil rights laws and it clarifies the standards that HHS applies in implementing section 1557 across all bases of discrimination. Section 1557 has been in effect since the ACA was passed in 2010. OCR has been receiving and investigating complaints since that time. The proposed rule is intended to provide clarity in more detail about consumer rights and obligations under section 1557.

While building on long-standing and familiar civil rights principles, section 1557 and the proposed rule take really important steps forward in the following ways. First, section 1557 is the first federal civil rights law to prohibit sex discrimination in health programs. Second the law extends nondiscrimination protections to individuals enrolled in coverage through the Marketplaces. Third, the proposed rule applies nondiscrimination principles to HHS's own health programs, ensuring that the Department is accountable to consumers. For example, although the department is already subject to laws prohibiting disability discrimination, the proposed rule extends protections against the other bases of discrimination to individuals who participate in HHS administered health programs. The bottom line is, consumers cannot be denied health services or health coverage, or discriminated against in other ways, in health services or coverage because of their race, color, national origin, sex, age, or disability. This means, among other things, that women must be treated equally with men in the health care they receive. Other provisions for the ACA bar certain types of sex discrimination in insurance. For example, by prohibiting women from being charged more than men for coverage. Under section 1557 women are protected from discrimination, not only in the health coverage they obtain but also in the health services they seek from providers.

The proposed rule also addresses some of the populations that have been most vulnerable to discrimination. For example, a provider can no longer turn away an individual who needs treatment for a broken arm because she is transgender. The proposed role enhances language assistance for those with limited English proficiency. The proposed rule codifies long-standing enforcement principles and incorporates a very flexible fact-specific standard under which the Office for Civil Rights will take multiple factors into account in determining what language assistance services an entity may need to provide, such as the cost of the language assistance services and the resources of the entity. The language assistance services may range from oral interpretation to written translation. The proposed role also requires effective communication for individuals with disabilities in line with already existing disability rights law.

The rule applies and prohibits discrimination by three types of entities. First any health program or activity that receives funding administered by HHS, such as hospitals that receive Medicare payments or providers that treat Medicaid patients. It also applies to any health program that HHS itself administers, such as Medicare or the Indian Health Service. And finally it also covers the Marketplaces and issuers that participate in the Marketplaces. The proposed regulation is independent of but complements other requirements such as those issued by CMS that apply to QHPs in the Marketplaces and health insurance plans marketwide.

We are seeking public comment on the role in a number of areas and the comment period ends November 9. We hope to hear from a large, wide range of stakeholders on these issues. And let me mention just a couple of these issues. The first is, the proposed rule makes clear the Department's commitment as a matter of policy to preventing discrimination based on sexual orientation and requests comment on how a final rule can incorporate the most robust set of protections legally available. The second issue that I wanted to mention that we are seeking comment on is that the proposed role requests comment on whether a religious exemption is necessary and if so what the scope of any exemption should be. Nothing in the law would affect the application of existing protections such as provider conscience laws. I'm happy to take any questions that you have. I am limited in what I can say because we are in the rulemaking process, but I will certainly try to answer your questions the best that I can. And we very much look forward to hearing from many of you and many stakeholders on these really important, historic nondiscrimination issues.

Great. Thank you so much, Sarah. We have one question that we'll ask you. I know that you said you cannot answer a lot of things, but the question is: Is there a protection for individuals with criminal backgrounds in this proposal?

The basis of discrimination isn't included in the statute but the proposed rule applies to all individuals. Regardless of whether you have a criminal background or not, if someone is discriminated against based on any of the bases listed (race, color, national origin, sex, age, or disability) then this proposed rule and section 1557 applies regardless of whether or not you have a criminal background or not.

Great. We will be sure to follow up with other questions that we get in, in a future newsletter with you. Thank you so much for taking time today. We also sent around information about this proposed rule in our September 9 assister newsletter, and we'll send these links around again in the newsletter next week in case anyone missed them.

Tax Tips during Open Enrollment

For our next update, we're joined by Kyle Miller, from our Exchange Policy and Operations Group here at CCIIO to provide some tax-related tips and reminders that assisters should share with consumers during Open Enrollment. Kyle?

Thank you. I just wanted to provide a few quick tips. I know it is a little bit early to think about tax season, but as we roll towards Open Enrollment there are a few things that correspond. To help reduce Form 1095-A errors and ensure timely delivery, we are encouraging consumers reenrolling in coverage through the Marketplace to make any changes or updates to their mailing address by November 15, 2015. We're providing this guidance to ensure that the changes affect the consumers' 2015 application and/or account and not their new 2016 information. As you know once December rolls around and someone creates an account for the following year, that makes it more challenging to make mailing address changes to the previous year's coverage. That plays a large role because that is where the 1095-A gets mailed. The second tip we have is that consumers enrolling in coverage through the Marketplace for the first time or who have not previously used an online account are encouraged to create an online account for January 1, 2016. We're providing this guidance to ensure that the changes allow for the initial 1095-A to be made available in the consumer's account immediately upon generation. We do an initial 1095-A Form generation on a rolling state-by-state basis through January, but we are not starting that process until the sixth. If a consumer is able to make an online account by January 1, that will ensure that the Form arrives when it is generated for them. We look forward to providing additional guidance in the coming months and appreciate the ongoing support on tax related issues.

Thank you so much, Kyle. That's it for Marketplace updates this week.

Periodic Data Matching

Now we are joined by Jessica Brill Ortiz, from the Exchange Policy and Operations Group here at CCIIO for a presentation on periodic data matching for consumers enrolled in both a qualified health plan with APTC and/or cost-sharing reductions, as well as in Medicaid or CHIP. As a reminder, if you have questions throughout today's webinar, please submit them through the webinar chat feature. Jessica?

Thank you. We wanted to share with you today about periodic data matching also known as PDM, which CMS has recently implemented and which refers to the process of identifying and notifying consumers who are enrolled in Marketplace coverage with APTC or CSRs and minimum essential coverage (MEC) Medicaid or CHIP. The presentation will include background on periodic data matching, what the consumer notification process is like, and why PDM is important for consumers, what assisters should know and how they can help, and also provide some pertinent resources. After that we will discuss in more detail one of the key ways assisters can help consumers who receive a PDM notice and need to end their Marketplace coverage with APTC/CSRs. On your screen you can see some background about periodic data matching. Under regulation, Marketplaces must periodically examine the available data sources to determine whether consumers who are enrolled in Marketplace coverage with APTC or CSRs have been determined eligible for Medicaid or CHIP, and also notify these consumers, and if the consumer doesn't respond to the notice, end their APTC or CSR. It is important to note that in 2015 the Marketplace will not take action to end consumers' APTC or CSR as a result of PDM. Consumers will need to take action on their own to end their Marketplace coverage with subsidies. Also if dually enrolled consumers do not end their Marketplace coverage with APTC, the tax filer will likely have to pay back some or all of the APTC received during the month the consumers are also eligible for Medicaid or CHIP. With a note being that liability starts the first of the month following that Medicaid or CHIP eligibility determination.

In terms of the consumer notification, CMS mailed paper notices to the household contact for consumers who may be dually enrolled. On this slide you can see the information that those notices included, such as the names of consumers who are found to be dually enrolled, the warning that individuals who were eligible for Medicaid or CHIP aren't eligible for financial assistance through the Marketplace, and also about potential tax liability when a consumer is dually enrolled as just described, instructions on how to end Marketplace coverage with APTC for those folks who are enrolled in Medicaid or CHIP, as well as a note that no action is needed at the Marketplace for consumers who are not enrolled in Medicaid or CHIP. The notice also provides contact information for the state Medicaid or CHIP agency, if consumers would like to confirm whether or not they are enrolled or if they have any questions.

Here it is important to note that not all dually enrolled consumers in all states will receive notices because not all states were able to fully participate in this round of PDM for technical reasons. Consumers in 10 states will not receive notices in this round. These states are Alaska, Delaware, Georgia, Maine, Michigan, New Jersey, Oregon, Tennessee, South Carolina, and Wyoming. We also went to caveat that sometimes states are not able to conduct the data matching process, so in participating states there may be consumers that are dually enrolled who may not receive a notice.

On this slide you can see a screenshot of a portion of a sample PDM notice and if you would like to see the entire notice, either in English or Spanish, both of those are available online on the page where the other samples are posted, and we'll provide that link at the end of the presentation.

There are several reasons why PDM and noticing is important for consumers. As I mentioned, it bears repeating because of the gravity of it, consumers who are determined eligible for MEC Medicaid or CHIP are not eligible for a Marketplace plan with APTC or CSR and should end their Marketplace coverage with those subsidies. If consumers were enrolled in Medicaid or CHIP do not end their Marketplace coverage with APTC or CSR, the tax filers will likely have to pay back all or some of the APTC received for a Marketplace plan from the month following the consumers eligibility determination for Medicaid or CHIP and they would have to pay them back when filing their tax return. Here we do want to note that consumers who are enrolled in Medicaid who still want a Marketplace plan would have to pay the full price without a tax credit or other cost-sharing reduction. In terms of some key things that assisters should know: we have outlined some reasons that consumers who receive the notice may contact assisters. We provided some information about how in particular you may be able to help these consumers. Consumers who receive a notice may contact assisters for a variety of reasons. The first most obvious being for help understanding the notice and hopefully this presentation will give you a good basis to be able to help consumers with those kinds of questions. Another reason consumers might reach out is for help ending their Marketplace coverage with APTC or CSRs. We have talked a little bit about that but the other resources slide that we will be getting too later in this presentation has a link for instructions on ending Marketplace coverage. It has a link for instructions geared specifically for consumers, as well as instructions to help assisters. Another reason consumers might reach out is if they do not think that they are enrolled in MEC Medicaid or CHIP. If they may have gotten the notice but don't think that it applies to them and don't think they got enrolled and that no further action is needed with the Marketplace. But they may opt to contact their state Medicaid or CHIP agency to confirm that indeed they are not enrolled in MEC Medicaid or CHIP. Contact information for those agencies is available in the notice. Consumers may also reach out if they want more information about Medicaid or CHIP or if they just are not sure whether or not they are enrolled in or have been determined eligible for either of those coverage programs. Consumers may contact their state Medicaid or CHIP agency to confirm that they haven't been determined eligible or that they are not enrolled in MEC Medicaid or CHIP and you can advise them to do that. As I just mentioned the contact information for those agencies is available in the notice. For these folks no further action is needed with the Marketplace, for folks who have not been determined eligible for or are not enrolled in MEC Medicaid or CHIP. The last scenario that we felt could be a reason that consumers would reach out to assisters is if consumers are enrolled in Medicaid or CHIP but believe that they are actually eligible to remain enrolled in Marketplace coverage with APTC or CSRs. So an example of this might be if the consumers' experienced a change in their family size or household income and that change makes them ineligible for Medicaid or CHIP. Here the consumers should contact their state Medicaid or CHIP agency to inform them of the change and to receive a redetermination of their Medicaid or CHIP eligibility. If they are found by the state to no longer be eligible for Medicaid or CHIP their coverage will end and the consumer can remain in their Marketplace coverage with subsidies if they are otherwise eligible to do so.

In terms of the estimated timeline for PDM notices were sent to consumers who may be dually enrolled this week, as identified through the periodic data matching process. We anticipate that additional PDM and notifying of consumers will take place in 2016. This is the other resources page that I have been referencing. We tried to pull together some materials that we thought would be useful and they include as I said, a presentation for assisters and others in the process of ending Marketplace coverage with APTC and CSRs as well as the link to instructions that are on HealthCare.gov that are geared more towards consumers who are trying to figure out how to end their Marketplace coverage they have or get Medicaid or CHIP. There is also a link to the page where a sample PDM notices are located in both English and Spanish. And there is a link to a frequently asked questions document focused on the topic of periodic data matching.

Great. Thank you, Jessica. I see that we have a lot of questions that have come in through the chat. I think that your next presentation will help answer a lot of the questions that we are getting. Let's go ahead and move on to the next one and we will save all of the questions for the end.

Terminating QHP Coverage

Next, Jessica will be sharing some information on how consumers who are in this situation can terminate their QHP coverage. Keep submitting your questions through the chat feature and like I said we'll address them at the end of the presentation. Jessica?

Great. Thank you. Since as we have just discussed a significant role that assisters could play in periodic data matching is helping consumers who receive the PDM notice to end their Marketplace coverage with APTC or CSRs, we wanted to take the opportunity to provide a refresher and update on what this process of ending coverage looks like.

Let's start by talking about application updates. Consumers as you know are required to update their application information if it changes at any time during the year and to do so within 30 days of that change. When an application is updated, the Marketplace may find that the applicant, for instance, who was previously enrolled in a QHP through the Marketplace with APTC or CSRs is now eligible for Medicaid or CHIP coverage.

Going to zip past some of the slides and some of the content in the interest of time and really try to focus in on what would be most helpful for the purposes of the periodic data matching discussion. But of course during Q&A we're happy to answer questions about any of the content. We wanted to hone in on what we thought would be most useful at this time. There is a slide that provides background information about assessment and determination states. But I wanted to pause for a minute and talk about program eligibility considerations that are important to mention. As you know after being determined eligible for Medicaid or CHIP that qualifies as a minimum essential coverage, a consumer is no longer eligible for APTC and CSRs through the Marketplace. For the first couple of points on this page cover what we've addressed in terms of tax liability and the need to end coverage. Consumers who receive APTC and have been determined eligible for or are enrolled in Medicaid or CHIP should take the steps outlined here in this presentation to end their QHP coverage with APTC or CSRs. In particular want to highlight that consumers in determination states should end their QHP coverage immediately after being determined eligible for Medicaid or CHIP. Consumers in assessment states should wait until being determined eligible for Medicaid or CHIP by the state Medicaid or CHIP agency before they end their Marketplace coverage with subsidies. Again I just want to flag that if a consumer who is enrolled in Medicaid wants to maintain their coverage in a QHP the Marketplace they would need to reapply for coverage without a financial assistance and do so during an open enrollment period or a special enrollment period if they are otherwise eligible to do so.

This presentation, as a primer since we'll be skipping through pieces of it, includes instructions on how consumers can end QHP coverage through the Marketplace with APTC or CSRs and break it down into different scenarios. Depending on the situation you're dealing with, the steps that you need to take to end coverage would be different. One scenario is when the Marketplace assesses or determines someone to be eligible for Medicaid or CHIP. Another scenario which is what we will be focusing on, is when a consumer is dually enrolled in Marketplace coverage with APTC or CSR as well as Medicaid or CHIP that qualifies as MEC. Beyond that the instructions are broken down into when all applicants have been assessed or determined Medicaid or CHIP eligible or are enrolled in Medicaid or CHIP and also when some applicants have been assessed or determined Medicaid or CHIP eligible or enrolled in Medicaid or CHIP but at the same time other folks on that same application remain QHP eligible.

Specifically the presentation covers three different sets of instructions. One on terminating Marketplace coverage with APTC for all enrollees. Another is canceling Marketplace coverage with APTC for all enrollees. What we will be focusing on is the third set of instructions which centers on ending Marketplace coverage with APTC or CSRs for some but not all enrollees on an application because we think this is probably the most pertinent to periodic data matching. In other words we think that most people who receive the PDM notice will need to end the Marketplace coverage for some of the people on the application but not for everyone. With that in mind, I am going to skip through much of the slides that you can access yourself online and get to the piece that I just spoke about.

Ending QHP coverage with APTC and CSRs for some but not all enrollees on an application. This would be used because of some folks have been determined eligible for or enrolled in Medicaid or CHIP but not all of them. As you can see the first step of course is logging into HealthCare.gov and clicking on Marketplace coverage for individuals and families. And then selecting the pertinent application.

From there you click report a life change. Then click report a life change button again – a green button at the bottom - you click on report a life change twice. On the next page you work through the application information. First with select report a change in a household income size or other information. You can see that is indicated by the blue arrow. And then continue at the bottom of the screen. From there continue through the application information updating information as necessary. At that point once you get to this screen about who is applying for coverage it is important to remove the people who are not applying for coverage. In the case of periodic data matching it would be the people who are enrolled in Medicaid or CHIP. They are removing themselves from the application for Marketplace coverage with subsidies. Click remove next to the names of those folks and click the green save and continue near the bottom of the screen. And you'll need to confirm the removals and answer any subsequent questions appropriately, again clicking the green save, and from they are continue to click your way through the application updating information as necessary until you get to the question about claiming dependents on the federal income tax return.

Here it is important to add back in any relevant members of the tax household. This is an opportunity to list the members in the applicant's tax household and this may include listing the people or person who were just removed as applicants. While they may not be applying for coverage through the Marketplace any longer because they have coverage through Medicaid or CHIP, if they are part of the tax household it is still important for them to be on the application. As applicable you will indicate whether the applicant is claiming dependents on their federal income tax return and answer any subsequent questions. And then click the green save and continue. And continue clicking through the application adding and updating information as needed.

At the eligibility results page which I know you are familiar with, you will want to click the view eligibility results button and when ready they continue to enrollment. There are a couple of really important notes here. What is that it is important to continue through the enrolled to do list including selecting and confirming a plan in order to complete this process. Also the plan subscriber or the policy holder will be automatically reassigned based on who the remaining enrollees on the application are. We also want to be clear about some important information regarding confirming enrollment for QHP applicants. The plan selection will only show the consumers who applied and who were determined eligible to enroll in a QHP through the Marketplace. Consumers who are assessed or determined eligible for Medicaid or CHIP or who are no longer applying for QHP coverage through the Marketplace such as those who were noticed in the PDM and are enrolled in Medicaid or CHIP those names will not appear. For consumers continuing their Marketplace coverage they must select and confirm enrollment in a QHP in order for these coverage changes to go into effect. Consumers who are eligible for a special enrollment period will be able to select a new plan if they wish. The last note on this topic is that once QHP enrollment is confirmed for the remaining applicants, at that point is when coverage will be terminated for the consumers who are either no longer applying for coverage through the Marketplace or who have been assessed or determine Medicaid or CHIP eligible. I wanted to give a quick mention here about obtaining a special enrollment period for coverage in a QHP. As you know consumers can receive a special enrollment period to enroll in coverage through the Marketplace. For a variety of reasons, one is that they are assessed eligible for Medicaid or CHIP by the Marketplace but they later receive a denial letter from the state Medicaid or CHIP agency. Another reason might be that they lose eligibility for Medicaid or CHIP outside of Open Enrollment and they want to apply for Marketplace coverage. A third would be if they have certain changes and circumstances or other qualifying life events.

While we walked through the process for consumers to end Marketplace coverage for some but not all people on the application, it is possible that a consumer will receive a PDM notice and that all people in the application may be dually enrolled and in that scenario all people would need to end their Marketplace coverage with APTC or CSR. The scenario on the screen right now addresses that situation. And refers to the specific instructions that are part of this presentation that would need to be followed. That would be the terminating Marketplace coverage with APTC and CSRs for all enrollees. I think that is a good overview of what we wanted to cover now and I'm going to hand it back over.

Q&A

Great. Think you so much Jessica. We have time to answer your questions. We are joined by Kelly Brown and Sarah Boehm also from the Exchange Policy and Operations Group, as well as Marielle Kress from the Center for Medicaid and CHIP Services to help answer questions. Our first question is: Why is this so important for consumers?

This is really important for consumers because consumers determined eligible for Medicaid or CHIP are not eligible for a Marketplace plan with APTC or CSRs and should end their Marketplace coverage with APTC/CSRs. If interested, these consumers may maintain Marketplace coverage without financial assistance. If dually-enrolled consumers do not end their Marketplace coverage with APTC, the tax filers will likely have to pay back all or some of the APTC received during the months the consumers are also eligible for Medicaid or CHIP. Here again, note that liability starts the first of the month following the Medicaid or CHIP eligibility determination.

Okay. So people seem to understand that, even if a consumer immediately responds to this notice by ending his or her Marketplace coverage with APTC, the consumer may still owe back advance payments of the premium tax credit for months when he or she was enrolled in Medicaid? Is that correct?

That is right. If a consumer is enrolled in Marketplace coverage with APTC or CSRs and is enrolled in Medicaid or CHIP, the tax filer(s) who claim this consumer as a dependent on their income tax return will likely have to pay back all or some of the APTC received for a Marketplace plan during the months following the consumer’s eligibility determination for Medicaid or CHIP.

Another question. Will people in states such as Michigan who did not get the notice be liable for repaying the amount back from the time before they receive the notice?

Yes. The liability is the same in all the Marketplace states. The notice is an extra step to notify consumers about this. But the liability stands for everybody who is dually enrolled and there are numerous other places that we have been making sure that this information and a warning to consumers is posted including a couple of the places on the application itself as well as in the eligibility determination notice that consumers receive because we really want to make sure -- as well as on the website -- because we want to make sure that consumers recognize that there is a liability for dual enrollment and we want to try to help them avoid it whenever they can.

Regarding periodic data matching, does the need to end Marketplace coverage apply if the consumer is eligible for Medicaid or CHIP but not enrolled?

The liability starts the first day of the month following the Medicaid or CHIP eligibility determination. If the consumer has been determined eligible, not assessed, but determined eligible for Medicaid or CHIP it is the first of the month following whenever that determination of occurred that liability will start. If a consumer received a determination on July 14, their liability for the dual enrollment would begin on August 1.

Okay. What if both parents live in separate households any do not communicate to each other that there is Medicaid or CHIP Marketplace insurance. Are they still responsible to repay the cost sharing or APTC?

Yes. If consumers are dually enrolled then the liability exists.

How do consumers get their premiums back from the insurance company when they enroll in Medicaid and cancel their Marketplace insurance?

Could you repeat the question?

How do consumers get the premiums back from the insurance company when they get enrolled in Medicaid and we cancel the Marketplace insurance?

There is no way for consumers to recuperate the premium payments from the issuer. Which is another reason why it is really important for consumers to end their QHP coverage with subsidies as soon as they receive a final eligibility determination for Medicaid or CHIP because not only will they have liability for the dual enrollments they will also be paying the premiums.

When does tax liability begin for the APTC received while enrolled in Medicaid or CHIP?

While tax liability is determined exclusively by IRS, according to IRS rules, the tax filers may be liable to pay back APTC for months the consumer is enrolled in a Marketplace plan with APTC/CSRs and Medicaid or CHIP beginning on the first day of the month following the Medicaid or CHIP eligibility determination.

Someone is asking - they are from Oregon – and there is a Medicaid program called the Citizen Alien Waived Emergent Medical. This Medicaid program only covered life-and-death emergency services and labor and delivery. These patients can be dually covered since their coverage is not considered a major medical coverage. Would consumers in this situation also be sent a letter?

If the Medicaid or CHIP coverage – sounds like Medicaid in this case – is not considered minimum essential coverage, then dual enrollment is not an issue. The issue for dual enrollment and the liability of the grounds in which consumers would receive this notice is that the Medicaid or CHIP that we believe they are enrolled in is considered minimum essential coverage.

How will consumers identify these notices, and what do the notices say?

The subject of the notice reads: “You’re getting this notice because some people in your household may be enrolled in both a Marketplace health plan and Medicaid or Children’s Health Insurance Program (CHIP) and you may need to take action immediately to end Marketplace coverage with advance payments of the premium tax credit.” The notice lists the consumers the Marketplace found to be dually-enrolled, and tells them to do one of two things: 1) if they are enrolled in Medicaid or CHIP, immediately end their Marketplace coverage with APTC/CSRs (the notice provides instructions on how to do so); or 2) take no further action if they are no longer enrolled in Medicaid or CHIP. The notice also provides instructions for consumers who want more information about Medicaid or CHIP, or if they aren’t sure whether they are enrolled in Medicaid or CHIP.

Is it correct that someone who is enrolled in Medicaid cannot also be enrolled in the Marketplace?

No. Someone who is enrolled in Medicaid, if they choose to maintain Marketplace coverage it would need to be unsubsidized (without APTC or CSRs) and they would need to apply during Open Enrollment or a special enrollment period if otherwise eligible for Marketplace coverage that is without financial assistance.

When and how are these notices being sent to consumers?

The Marketplace mailed paper notices in September 2015 to the household contact for applications with consumers who may be dually-enrolled. The notices are not available electronically in consumer user accounts. As I said, they were mailed through the postal service. Paper notices are what consumers will be receiving. Additional data matching and notifying of consumers will occur in 2016. Updates will be provided when more information is available.

What if the consumer is enrolled in Medicaid or CHIP but believes he or she is actually eligible to remain enrolled in Marketplace coverage with APTC/CSRs?

A consumer may believe he or she is eligible to remain enrolled in Marketplace coverage with APTC/CSRs in the following scenario: A consumer is enrolled in Medicaid/CHIP and Marketplace coverage with APTC, but has experienced a household or income change that makes him or her ineligible for Medicaid/CHIP. The consumer should contact his or her state Medicaid/CHIP agency to inform them of the change and receive a redetermination of eligibility for Medicaid/CHIP. If the consumer is found to no longer be eligible for Medicaid or CHIP, his or her coverage will end; the consumer can remain in his or her Marketplace coverage with APTC/CSRs, if otherwise eligible.

Why would consumers be enrolled in both Marketplace coverage with APTC or CSRs and Medicaid or CHIP coverage?

Consumers may become eligible for Medicaid or CHIP after being enrolled in a Marketplace plan with APTC/CSRs for many reasons, including after experiencing a drop in income or after being determined eligible for Medicaid due to disability or having other long term services and support needs. While the Marketplace reinforces in many places the importance of reporting changes to the Marketplace and ending Marketplace coverage with APTC after being determined eligible for or enrolling in other minimum essential coverage, this notice is a reminder to these consumers who may not have been aware that they need to end their Marketplace coverage with APTC.

If a consumer is dually enrolled during reconciliation is the entire tax credit owed back even if perhaps some of the members of the household are still enrolled and QHP eligible.

That is a really good question. The taxpayer will owe back the APTC received on behalf of the consumers who were dually enrolled. It is not the tax credit for the entire household but the tax credit that relates to the dually enrolled consumers.

In addition to cancelling their plan will consumers also need to contact their insurance company as well?

No, if they follow the instructions that we have just walked through, or whichever set of instructions that pertains to them, that will not only end their coverage but it will also send the information to their issuer. They do not need to reach out to the issuer on their own but again it is really important that they follow the instructions and particularly the piece that we talked about if they are only ending for some people on the application but not all that they go all the way through plan enrollment and confirm enrollment for the remaining people on the application because that is what will actually terminate coverage for those who are removing themselves.

Can make consumer keep coverage with APTC and CSRs even after they're found to be eligible for Medicaid?

Consumers who do not end Marketplace coverage with APTC or CSRs after they been determined eligible for Medicaid be liable as we've been talking about to repay the APTC and CSR received after the eligibility determination date. That is why we are encouraging anyone who is dually enrolled or who has just received a Medicaid or CHIP eligibility determination to come to the Marketplace or contact someone to help them to end their Marketplace coverage with APTC or CSRs.

We have another state specific question. In North Carolina we have Medicaid assessment. Sometimes it can take months for the approval and coverage is backdated to the date of the application. In this situation will consumers be liable during the backdated period?

No, the consumer -- the taxpayer for the consumer, which may be the consumer themselves or someone else -- will only be liable starting the first of the month following whenever that determination was made. It is the case in many states that when Medicaid is granted -- when someone is determined eligible the coverage -- will go back to the application date or even three months prior to that and any of that time does not count as time in which the consumer or the tax filer is liable. Liability only begins the first of the month following the date of the determination. Just to trot out an example if the consumer receives an eligibility determination that they were eligible for Medicaid starting on July 2 and coverage was effectuated retroactively back to sometime in May the consumer or tax filer wouldn't be liable until August 1.

When consumers remove a member of their family from the plan will the remainder of the family be able to enroll in a new plan if they want to?

If they were eligible for a special enrollment period. But if they are just terminating coverage for one person, then not necessarily. Only if they're eligible for a special enrollment period can they change plans.

Closing

Great. I think we got to a lot of everyone's questions. I know there are probably more that we did not get to. We will follow up with more answers to your questions in a future newsletter. Thank you for submitting all of your questions today. Special thanks to our presenters Sarah, Kyle, and Jessica for joining us today. Our next webinar will be next week, which is Friday, October 9 at 2 PM Eastern time. As a reminder, if you would like to sign up for the CMS Weekly Assister Newsletter listserv and webinar invitations, please send a request via the Assister Listserv inbox (ASSISTERLISTSERV@cms.hhs.gov) and write "Add to listserv" in the subject line. Finally, we want to once again say thanks so much for all your hard work as we prepare for the next Open Enrollment Period! Have a fantastic weekend.